

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control**

Board of Scientific Counselors



**Fifteenth Meeting
December 9, 2014
Summary Report**

Table of Contents

Call to Order / Introductions	Error! Bookmark not defined.
Director's Update	Error! Bookmark not defined.
Discussion Points	6
Science Update.....	Error! Bookmark not defined.
Discussion Points	8
NCIPC Injury Control Research Centers	Error! Bookmark not defined.
Discussion Points	12
Update: Pediatric Mild-Traumatic Brain Injury Guideline	Error! Bookmark not defined.
Discussion Points	19
Updates: WISQARS Portfolio Workgroups.....	Error! Bookmark not defined.
Discussion Points	22
Public Comment Period	Error! Bookmark not defined.
Closing Comments / Adjourn.....	Error! Bookmark not defined.
Certification.....	Error! Bookmark not defined.
Attachment A: Meeting Attendance	Error! Bookmark not defined.
Attachment B: Acronyms Used in this Document	Error! Bookmark not defined.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)**

BOARD OF SCIENTIFIC COUNSELORS (BSC)

Fifteenth Meeting: December 9, 2014

Via Teleconference

Summary Proceedings

The fifteenth meeting of the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) took place via teleconference on Tuesday, December 9, 2014. This meeting of the NCIPC BSC was open to the public in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA). Dr. Carolyn Fowler served as chair.

Call to Order / Introductions

Carolyn J. Cumpsty Fowler, PhD, MPH
Assistant Professor
Johns Hopkins University School of Nursing
Bloomberg School of Public Health
Member and Chair, NCIPC Board of Scientific Counselors

Dr. Carolyn Fowler officially called to order the fifteenth meeting of the NCIPC BSC at 9:00 am on Tuesday, December 9, 2014. She welcomed everyone and expressed appreciation for their time and commitment to injury and violence prevention, and requested that Mrs. Tonia Lindley conduct the official roll call.

Mrs. Tonia Lindley conducted a roll call of NCIPC BSC members and established that a quorum was present. A list of meeting attendees is provided with this document as Attachment A. **Dr. Fowler** then requested that those present introduce themselves.

Dr. Fowler requested a motion for approval of the June 2014 NCIPC BSC meeting minutes.

Vote: Approval of Minutes

Dr. Allegrante moved to approve the June 5-6, 2014 NCIPC BSC meeting minutes. **Dr. Hamby** seconded the motion. The motion passed unanimously with no abstentions.

Director's Update

Debra Houry, MD, MPH

**Director, National Center of Injury Prevention and Control
Centers for Disease Control and Prevention**

During this session, **Dr. Houry** provided an organizational update on some leadership changes, framing around NCIPC's organizational strategy, her background and vision for NCIPC, and a brief science update.

In addition to Dr. Houry's appointment as NCIPC's Director, the following leadership changes have occurred within NCIPC:

- ☐ Amy Peebles has been selected as Dr. Houry's Senior Advisor after returning to NCIPC as Acting Deputy Director
- ☐ Dan Cameron has been selected as NCIPC's new Management Official
- ☐ Dr. Jim Mercy is currently replacing Howard Spivak as acting Director for the Division of Violence Prevention (DVP)
- ☐ Lee Annest will be retiring as Branch Chief of Statistics Programming and Economics Branch, with more than 30 years of service to NCIPC

Staffing changes aside, Dr. Houry emphasized the continuing commitment to NCIPC's mission to prevent violence and injuries, and reduce their consequences.

At the time of this meeting, Dr. Houry had been with NCIPC for about two months. Prior to joining CDC, she served as Vice-Chair and Associate Professor in the Department of Emergency Medicine at Emory University School of Medicine and as Associate Professor in the Departments of Behavioral Science and Health Education and in Environmental Health at the Rollins School of Public Health. Dr. Houry also served as an Attending Physician at Emory University Hospital and Grady Memorial Hospital, and as the Director of Emory Center for Injury Control. Her prior research has focused on injury and violence prevention in addition to the interface between emergency medicine and public health, and the utility of preventative health interventions and screening for high-risk health behaviors.

In terms of Dr. Houry's vision for NCIPC, she has met one-on-one with most staff members and plans to complete the remainder of these meetings by the end of the year. She stressed that she has been invariably impressed with the dedication of NCIPC's staff and the quality of the work undertaken there. She wants to preserve the great work done at NCIPC while fostering an injury center that is big, bold, and innovative; that understands its specific value-added and maximizes it; and that routinely evaluates its priorities in program, research, surveillance, and policy to ask the following questions:

- ☐ How we can work smarter, not harder?
- ☐ How we can work more collaboratively?
- ☐ How we can achieve the most with finite resources?

To ensure that NCIPC can achieve results, Dr. Houry is committed to increasing capacity in the center and aligning NCIPC's capacity with its priorities. She is working to improve staff recruitment and retention and fill key vacancies by streamlining the hiring process, improving candidate selection, and conducting exit interviews. The Federal Employee Viewpoint Survey (FEVS), a government-wide satisfaction survey, is being used to track NCIPC's progress in these areas. Efforts are being made to increase the response rate to ensure that the data are accurate as possible. One of NCIPC's key commitments is to maximize its impact by scaling up what works and fostering innovation. Of particular interest is fostering innovation in a few key areas, including: 1) helping clinicians to improve population health; 2) developing and disseminating tools, such as Motor Vehicle Prioritizing Interventions and Cost Calculator for States (MV PICCS), to help decision-makers better understand the cost-effectiveness of different evidence-based strategies; and 3) strategically using public and private sector partners to expand the reach of our work.

In terms of moving forward, over the next two to three months, NCIPC will be asking each office and division to think about identifying its strategic priorities for the next two to three years and to review prior research plans and strategic plans. The leadership team will develop some specific goals to help guide the center forward for the next few years. In January, the senior leadership team will meet to reevaluate NCIPC's priorities to ensure that the center maintains a focus on the primary prevention of high burden topics and is taking advantage of opportunities in the public health landscape, such as increasing collaboration with the healthcare sector.

Regarding science updates, Dr. Houry referred participants to their packets for highlights of NCIPC's major accomplishments since the BSC met in June 2014. She explained that later in the agenda there would be time to entertain questions regarding the center's accomplishments. Rather than report-outs, the BSC meetings are being reframed to better engage members with some of NCIPC's most pressing issues and questions. This year, NCIPC will be soliciting proposals for five Funding Opportunity Announcements (FOAs), four cooperative agreements, and one grant. Three FOAs have been published, with the other two expected to be published within the coming weeks. The FOAs will address the following areas:

- ☐ Evaluating Structural, Economic, Environmental, or Policy Primary Prevention Strategies for Intimate Partner Violence (IPV) and Sexual Violence (SV) (published)
- ☐ Evaluating Innovative and Promising Strategies to Prevent Suicide among Middle-Aged Men (published)
- ☐ Research to Evaluate the CDC Heads Up Concussion Initiative in Youth Sports (published)
- ☐ Competitive renewals and invitation for new awardees for The CDC National Centers of Excellence in Youth Violence Prevention: Building the Evidence for Community- and Policy-Level Prevention (not yet published)
- ☐ RO1 Research Grant for Preventing Violence and Violence Related Injury (not yet published)

In closing, Dr. Houry said she looked forward to working closely with the BSC and finding better ways to utilize the members' expertise and knowledge moving forward.

Discussion Points

Dr. Fowler pointed out that the BSC has been having a conversation for the last eight years about how the committee can be more actively engaged. There has been discussion about a website, working groups and Management Analysis and Services Office (MASO) restrictions, among other topics. However, she personally has not observed any progress toward that. She thought it would be helpful to have a conversation about the FACA rules regarding what the BSC can and cannot do, as well as how the members can be more constructively engaged. It is challenging to raise this issue repeatedly. The BSC is very willing to work with NCIPC to be helpful, but requires assistance with improved communications.

Dr. Houry replied that this is something they plan to look into. While she has not served on the BSC, she has been a peer reviewer and has been involved in other external workgroups. When she and Dr. Greenspan reviewed the agenda, Dr. Houry mentioned that she does not like being on conference calls on which there are lots of report outs because then she is on her computer checking email, going down the hall to get more coffee, et cetera. She thought it was important to reframe the agenda so that there is more discussion versus report outs.

Dr. Greenspan acknowledged that there has been a significant amount of discussion about the BSC's role, and expressed her hope that the day's agenda would reflect what NCIPC hopes to have in terms of BSC engagement in the future on critical issues to gain input before moving forward with any final decisions.

Dr. Houry invited anyone with additional ideas that they would like the BSC to be involved in to submit them via email so that NCIPC can explore those and offer a status update sometime in January.

Regarding the engagement of the practice community and the private sector, **Dr. Fowler** emphasized the BSC's interest in NCIPC being proactive in addressing this issue in terms of ways to reconnect in some sort of advisory capacity with practice partners who used to be part of NCIPC's Advisory Committee for Injury Prevention and Control (ACIPC), but then were not included in BSC, due to the requirement of having scientists on the Board. Another issue would be NCIPC's plans for expansion of the private/public partnership for injury prevention.

Dr. Greenspan pointed out that since changing to a BSC, NCIPC realized the deficiency of some formal mechanism of engaging the practice community. Dr. Greenspan; Sara Patterson, NCIPC's Office of Policy and Partnership Director; and Erin Connelly, NCIPC's Office of Communications Director, have been working toward developing a parallel group in order to obtain more formal engagement from the practice community. As a start, they will be reaching out with surveys and questions to the practice community. Because of NCIPC's limitations, that will probably be less than 10 people. Perhaps they will have a more generic conversation with more people. Then decisions can be made about how best to engage the community. Once they have talked to the practice community, another issue will regard how to create a dialogue between the BSC and the practice community. NCIPC is clearly aware that this is an issue, is actively working to resolve that, and will have more information by the time of the next BSC meeting.

Ms. Patterson added that outreach is being conducted through the Injury & Violence Prevention Network (IVPN). Approximately 15 to 20 organizations have already volunteered to be interviewed in some way. Erin Connelly is developing the questions that will be asked, and a decision must be made about who will receive formal interviews versus those with whom there will be less formal discussions. This is very exciting, given that the practice community is very interested in how to provide input. Consideration is being given about how to link this group with the BSC to make sure that there is seamless interaction, bearing in mind the rules that must be followed. Ms. Patterson's office has been engaged in developing a business partnership plan over the past couple of years, with a focus more recently on private business partnerships in two areas that have arisen as priorities: 1) NCIPC's Violence Against Children Surveys (VACS): Because there is no funding to conduct these with CDC's domestic appropriations, other funds must be found in order to continue to expand the number of surveys; and 2) Prescription drug overdose issues: Ms. Patterson has attended a couple of broad cross-sector meetings recently that have addressed this issue, and they have been talking with the CDC Foundation as well.

Dr. Edgerton welcomed Dr. Houry and expressed excitement as a pediatric emergency physician to have her clinical perspective. Building on the conversation of the intersection of public health and clinical practice, Dr. Edgerton asked whether Dr. Houry had any thoughts on some of the synergy within CDC in the past, especially at NCIPC, with the impact of emergency medical services and injury on healthcare. She oversees the Emergency Medical Services for Children (EMSC) for the Children's Program at the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). Many other federal partners and liaisons represent the larger emergency medical services (EMS) community. Private partnerships would be providers who serve in that capacity. She wondered whether Dr. Houry had any thoughts or strategies about that for the future.

Dr. Houry replied that she is still going through the briefings and did not want to speak out of line. While her background is in emergency medicine, NCIPC's focus is on primary prevention. Therefore, any work with EMS partners would have to be focused on primary prevention as well. There are ways to do this. NCIPC recently developed a new strategic plan and is thinking about shifting the approach to the intersection between clinical medicine and public health by looking at primary care physicians and that intersection. She sees that as one of the first ventures. The plan is to have all three division directors and the Associate Director for Science (ADS) meeting in January to discuss the focus areas. There is an effort to move away from calling these "priority areas" within all of NCIPC's topics. During this meeting, they will discuss how to engage partners such as EMS, pediatricians, and the business sector.

Dr. Fowler inquired as to whether Dr. Houry or other EMS-connected members of the committee had any intention of working with EMS credentialing in terms of the importance of preparing EMS providers at all levels to be able to deliver evidence-based interventions in prevention programs as opposed to marketing.

Dr. McClure, Director of the Division of Analysis, Research, and Practice Integration (DARPI) at NCIPC, responded that there was a discussion during the last BSC meeting about the possibility of recognizing that the trauma system's accreditation has a requirement that primary prevention be part of the trauma system. There are Primary Prevention Coordinators, who are part of the designated trauma system. He believes this is an area in which they can become involved, given the focus on primary prevention. He also suspects that this system has been growing independent of public health departments' primary prevention activities. There is a recognition

that there is a workforce of primary prevention practitioners with whom NCIPC can formalize its engagement. He welcomed any comments about that.

Dr. Edgerton suggested that they follow-up with a call after the meeting, because there has been a lot of activity at the intersection of EMS as the trauma centers of primary prevention, as well as models of community care medicine for pediatric and adult populations.

If permissible, **Dr. McClure** thought that an independent call would be wonderful.

Dr. Fowler suggested that Dr. McClure contact some of the BSC members who are involved in this area. It is interesting to note that in trauma surgery, the requirements for the Coordinator position were in place before the requirements that the work be evidence-informed. It would be extraordinarily helpful to be able to shift the quality of work being done in EMS.

Dr. Mickalide inquired as to whether there might be a role for the BSC to offer input into priority areas for funding in future years.

Dr. Houry responded that this is an appropriate role for the BSC, and discussion time can be built in to make this a standing BSC agenda item.

Dr. Fowler indicated that in the past, the BSC expressed concern about NCIPC selecting priority areas. While the rationale for that is understood on one level, several members suggested that the word “priority” not be used due to the concern that it may lead to the inability for people to address other topics. In fact, that did occur. Thus, the BSC welcomes and appreciates Dr. Houry’s being receptive to input on funding areas.

Science Update

Arlene Greenspan, DrPH, MS, MPH
Senior Scientist, Motor Vehicle Injury Prevention Team
National Center of Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Greenspan reminded everyone that a list of NCIPC’s accomplishments since the last BSC meeting was included in the members’ packets. She noted that while NCIPC prefers to provide updates earlier than they were able to this time, there were issues with MASO, which oversees all of the FACA-chartered committees. Given that written materials were provided, she opened the floor for discussion and invited those who had not had time to review the materials or thought of additional questions later to email them to Mrs. Lindley to be triaged and distributed to those who could be respond.

Discussion Points

Regarding the DARPI update, for the topic of “Unintentional/Fall-related ED visits in the very old (65-100+),” it was noted that 65 is not really “very old,” and an inquiry was posed regarding whether any comparisons are being made of the “younger old” versus the “older old.”

Dr. McClure responded that they are, and he recognized the comment on the “very old” and 65, wording which may need to be changed. That is the cutoff that the branch has used, and the emphasis is really on the dramatic increase between 65 and 100+. Obviously, there are limited

numbers in the 100+ category. This is a very specific piece of work, with the findings pertaining to the dramatic increase in risk with increasing age.

NCIPC Injury Control Research Centers

Arlene Greenspan, DrPH, MS, MPH
Rod McClure, MBBS, PhD, FAFPHM, FAICD
National Center of Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Greenspan indicated that those who were currently associated with an NCIPC Injury Control Research Center (ICRC) or who planned to apply for funding through the ICRC program must recuse themselves. Drs. Fowler and Johnson recused themselves during this session due to conflicts of interest (COIs). Dr. Greenspan pointed out that the ICRC program is NCIPC's largest grant program. Given that there have been ICRCs for over 20 years, it seemed like a good time to assess the program to determine whether there should be any modifications in terms of who is eligible to apply and/or how the program is operated.

NCIPC supports the development and maintenance of a network of ICRCs throughout the US in order to increase the success of NCIPC efforts to reduce mortality and morbidity from injury. The role of the ICRCs as participants of the ICRC program supported by NCIPC have been described as "an extension of NCIPC" and is characterized by five specific responsibilities:

- a. Engage with the State based institutions and networks (including the State Health Departments) to support evidenced based injury prevention practice
- b. Collaborate with the intramural NCIPC subject matter experts (SMEs) to maximize responsive development and translation of strategic/priority driven science
- c. Develop the future injury research workforce
- d. Establish a pipeline of knowledge innovation for injury prevention
- e. Be leaders in the injury prevention field

Listening sessions were convened that included all of the ICRC directors, and input was solicited through the Society for Advancement of Violence and Injury Research (SAVIR) in order to acquire a broader input from people engaged in the injury and violence prevention research community. The following table reflects the major findings of those discussions, each of which Dr. Greenspan reviewed during this session:

Question	Points For	Points Against	On Balance
1. Should the ICRCs be funded by Grants (vs Cooperative Agreements)	Grants deliver greater innovation, and incentivize greater ownership/ leadership/university engagement than research contracts and cooperative agreements [Note: The ICRC grant is one of the only grants left in the NCIPC] Allow current changes in post-management to mature to determine if changes will meet CDC needs without the need to change to a cooperative agreement mechanism	Grants are less efficient than contracts or cooperative agreements for delivering products directly relevant to current CDC problems of the moment. Greater collaboration between CDC and ICRCs would ensure greater CDC awareness of ICRC projects and create increased collaboration and more opportunity to align goals	Responsibilities in a and b above can best be served by Cooperative Agreements, however c, d and e are best served by a Grant arrangement. On balance it would be simplest to persist with Grant arrangements although, a split system with Cooperative Agreement plus grant allocation for research would be an option (see next row)
2. Would changing the mechanism to a cooperative agreement for core functions (including teaching/outreach) with separate FOAs for research projects, eligible to only ICRC grantees, improve flexibility/usefulness and responsiveness of the research?	This would increase relevance and responsiveness to NCIPC needs	It may increase burden on ERPO It reduces ICRC autonomy to develop their own research program.	On balance no clear preference. For discussion.
3. Who is eligible for next funding round (or un/favorably advantaged)			
a. Sunsetting	Increases the opportunity for new research groups to obtain support from CDC. [Although sunseting may not be needed to achieve changing of the guard, because evidence suggests the highly competitive market place ensures shifting of funding occurs simply by relying on merit assessments]	Not merit based De-funded centers may fold without support resulting in no net gain (hence may reduce return from previous investment) Discourages universities from committing support to their centers because universities think they are setting themselves up to provide even more support once the CDC funding goes	On the basis that it is in CDC's best interests to maintain the highest quality program, then reject the sunseting option
b. Multifocal (vs single focus Centers)	Arguably multifocal centers are better able to support their local state based partners to address the range of problems faced	No multi-focal center is large enough to cover the territory and still only provides patchy coverage across the broad field of injury prevention At least single-focused centers are truly international experts in their focus area	The arguments for and against are not sufficiently strong to support a radical change. Recommendation is to leave as is, pending further discussion
c. Achieve balanced geographical distribution of the ICRCs	The current dramatic imbalance on the east appears as though the federal government is neglecting a large part of the US population Local partnerships are easiest and best to facilitate – understanding of local issues and face-to-face still important	Not merit based Given ICRC state collaboration has been shown to work best when they are co-located in the same town, balancing ICRC distribution across the state may be more cosmetic than useful	Suggestion we retain merit based allocation of centers, BUT, with geographic distribution being used to separate equally ranked centers (or perhaps switch the rank order by one place if the scores are close)
d. Developmental Centers?	Increases the opportunity for new research groups to obtain support from CDC	We do not have the funds to support this concept Our experience in the last funding round is a strong argument against this concept	Reject these for next time round

Dr. Greenspan requested that the BSC members consider whether there were any gaps in the major areas, whether NCIPC was off-target about any of the issues, and any additional suggestions that NCIPC did not think of that could be reflected in future FOAs.

The ICRCs have been a grant program from the outset. Regarding whether this should continue as a grant program or should be switched to a cooperative agreement, the closest program at CDC that is analogous to NCIPC's ICRC program are the Prevention Research Centers (PRCs) funded through the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). The PRCs are funded through cooperative agreements. Shifting the funding mechanism for ICRCs to cooperative agreements would result in closer ties with

NCIPCs intramural research. NCIPC is trying to facilitate more collaboration and communication with intramural research. Given that much of NCIPCs extramural funding is through cooperative agreements at this point, it would be beneficial to retain some innovation through grant programs. In addition to being research programs, ICRCs also have other cores that include training and partnership outreach programs. One thought was to have a hybrid funding mechanism that would be in the form of a grant for the research component and a cooperative agreement for the training and partnership outreach programs. At this point, NCIPC's preference is to maintain the grant format to encourage innovation, but wanted to hear the BSC's thoughts on grants versus cooperative agreements.

The last FOA included a statement about sunseting the ICRCs that had been funded for two grant cycles for at least 10 years. NCIPC is currently revisiting this matter. The issue regards the fundamental role of ICRCs and whether the goal is to increase the number of ICRCs throughout the country, or if it is to fund the best ICRCs with the highest quality. For those ICRCs that have been successful for more than two grant cycles, should quality be the defining characteristic or should ICRC's be time-limited? There has been a significant amount of internal discussion about this. Over the years, some ICRCs have not been successful in competitive renewals. Given the limited resources, NCIPC's thought has been that it is more important to have quality than to sunset some of the best and longest running ICRCs. However, the need to bring on new talent to foster other ICRCs is also recognized. That has been the tension for NCIPC in this area. If sunseting is a consideration, it is important to develop a plan to ensure survival of ICRCs after CDC is no longer funding them. NCIPC's inclination has been to let the review process take its course and to not sunset ICRCs, but BSC input would be welcomed on this matter.

In terms of the issue of multi-focal versus single focus centers, the original ICRCs that were funded were all multi-focal in that they addressed a wide variety of injury areas. In more recent cycles, specific centers have successfully competed in single focus areas. Concern was raised in one of the listening sessions that these are very different areas and it is difficult within the same FOA to have both single and multi-focal centers. Single focused centers may have a tighter FOA and more substance because they focus on only one area, and perhaps offer an advantage in terms of competition. If single focus centers are believed to be important in terms of having a national authority in one area, should NCIPC be deliberate about specific areas that are more consistent with its own focus areas rather than permitting a single focus center to compete in any area? NCIPC's current thought is not to deviate substantially from previous FOAs, but perhaps to ask for specific areas if single focus centers are going to be permitted. It is theoretically possible for a single focus center in an area that is not really a focus area for NCIPC or that may not be a major burden area to submit a tight application that scores high.

Regarding reach/geographic diversity, the existing ICRCs are primarily concentrated on the East Coast. That is because in more recent years, NCIPC has funded the highest quality proposals received. At times, geographic diversity has been included in FOAs. However, that has not been included during at least one or two cycles. NCIPC's thought is that while they want to fund the highest quality proposals, geographic balance is important and should be included in the next FOA as just one factor. That way, if two proposals score equally or one scores just below the other but would provide a better geographical balance, NCIPC would have the potential to reach down and bypass one proposal to achieve geographical balance. However, they would not reach down far enough that they would be funding poor proposals.

In terms of developmental centers, people have expressed interest in bringing new centers on line. With the last FOA, NCIPC's thought was to have a separate solicitation for developmental centers that would not receive quite as much funding as comprehensive centers and would need to have never been funded as an ICRC. After one cycle of a developmental award, those centers would then be capable of and eligible to compete with other comprehensive centers that are already funded. The reality was that while NCIPC hoped to fund two developmental centers, the funds received allowed them to afford only one developmental center out of 23 applications. There was some consternation in the applicant pool about NCIPC's ability to fund only one developmental center. While NCIPC believes that it is a great idea to fund developmental centers, they simply do not have the funding to support a comprehensive and developmental program. Are there other ways NCIPC can encourage new centers to become competitive?

One issue that arose in discussions with senior leadership was getting all centers on the same funding cycle. Originally when there were two different cycles, they were based on geography. Over time, because of differences in funding, the two cycles are no longer used for geographic diversity. Because of funding issues, there is also greater imbalance in terms of how many centers are funded on each cycle. The suggestion has been made that all centers be moved to the same cycle, which would mean that in the next FOA, centers would be funded for a three-year cycle in order to put everyone back on a five-year cycle in the course of one cycle.

With respect to next steps and moving forward, NCIPC remains committed to the ICRC program, believes that ICRCs are "greater than the sum of their parts," and thinks they are important in terms of moving the injury field forward.

Discussion Points

Grants versus Cooperative Agreements

Dr. Mickalide emphasized that cooperative agreements provide an opportunity for the federal agency and ICRCs to be nimble in their responses to emerging issues. An ICRC may be focused on particular issues and are not able to address emerging issues. For example, this has been observed with prescription pain medication in the last four to five years.

Dr. Edgerton agreed that a cooperative agreement format would allow for some nimbleness to address issues that cannot be anticipated or areas of focus.

In terms of nimbleness, Dr. Greenspan pointed out that ICRCs are funded for five years. Regardless of whether there is a cooperative agreement or grant structure, once that is set and funded, it is difficult to make changes. One of the other discussions NCIPC leadership had regarded whether research should be funded for the entire five years versus having three-year grant programs that would facilitate more frequent types of grant structures. It was not clear to her whether the cooperative agreement versus grants would address the issue of nimbleness.

Dr. Houry noted that Dr. Williams-Johnson had the idea of getting the ICRCs on the same cycle, but to do that would require moving from a five- to a three-year cycle. That would stall changing being responsive to topics, but at the end of a three-year cycle everyone would be on the same cycle and consideration could be given to cooperative agreements versus grants.

Dr. Gorman-Smith agreed with the point about the ability to be more nimble with a cooperative agreement. Regarding the three- versus five-year structure, she expressed concern that five years often seem short. This is particularly true for new centers. A potential downside of moving to a three-year structure would be almost constantly having to think about writing the next application, and how that might impact nimbleness. Another concern with cooperative agreements pertains to the turnover that occurs within CDC, which can be a barrier to the work being done. In thinking about moving to a cooperative agreement structure, consideration must be given to the stability of staffing over time because that can undermine progress.

Dr. Mickalide asked whether it would be possible to structure a funding mechanism with 85% of an award fixed in a grant format and 15% to 20% set aside in a cooperative agreement format to respond to emerging issues.

Dr. Greenspan replied that NCIPC is considering a hybrid model.

Dr. Williams-Johnson said this would have to be structured and managed as separate mechanisms in terms of what NCIPC would want to accomplish. The cooperative agreement would have to be structured for program efforts over the five years, which would allow them to entertain new activities each year.

Regarding three- versus five-year funding, **Dr. Houry** clarified that there would be a one-time three-year cycle for the purpose of getting all of the ICRCs on the same cycle. The ICRC grants already have fairly limited funding, but there are mechanisms other than just the ICRC grants to address emerging priority areas. For example, funding is allocated to states for prescription drug overdose. Consideration could be given to how to encourage states to work with ICRCs when they receive those funds.

Dr. Greenspan agreed that the conversation about how to make ICRCs more nimble within a standard five-year cycle is of interest, but further consideration must be given to what type of mechanisms might be available to accomplish this.

It appeared to **Dr. Nation** that in terms of the responsibilities of ICRCs, there is an attempt to balance technical assistance and research. Given that NCIPC has new leadership, he wondered about the long-term thought about the ICRCs in terms of whether it would be to maintain the status quo or if there is a sense of wanting to move the ICRCs more toward one or the other. Research is expensive, and the grant model is probably the most expensive mechanism. Given that funding has been an issue for the last several years, NCIPC has been working with less money over time even though the absolute dollars may have been the same or slightly increased. This is starting to feel like a “zero sum” dilemma. It is unclear whether the granting mechanism is the most effective way to help NCIPC accomplish all five of the ICRC responsibilities.

Dr. Houry responded that while this is tough to answer, there is a specific line item in the budget for ICRCs. The hope is that having everyone on the same cycle will be helpful. A lot of the work ICRCs do is unfunded and is built on collaboration. NCIPC is not funding the entire ICRC program. This is just part of the portfolio. The hope is to fund smaller research projects that end up being larger RO1s, and help fund fellowships that can develop the next generation of injury and violence prevention researchers. She finds that to be very important. There is also a lot of research that NCIPC cannot do intramurally that ICRCs can do extramurally. ICRCs are integral to that. Conversely, ICRCs need to consider how they can continue to grow their own funding and sustainability by establishing other partnerships with other federal agencies,

businesses, and within their own universities. ICRCs come and go based on funding. Without CDC funding, a lot of essential ICRCs have not been sustained and NCIPC would not like for this to continue. It is important to show the value of ICRC dollars and ask people how they are going to maximize and match that. It would be great to increase the dollar line for ICRCs. Unfortunately, people are not excited about funding research centers. They want to fund specific topics per se. Therefore, she does not anticipate an increased line item for ICRCs unless the ICRCs are successful in working with their own state legislators to change that.

Dr. Allegrante said he understood the purpose of the conversation, but that he thought NCIPC should preserve this mechanism at CDC. There is a tension between preserving investigator-initiated research from the field with funding mechanisms that allow NCIPC to pursue topics for which they essentially want to contract. As mentioned, there could be a possibility for a combination of some proportion of funding to be in the form of a grant and another proportion to be in the form of a cooperative agreement. He suggested piloting a hybrid before moving to a new model. He asked Dr. Greenspan to discuss what she thinks might occur in light of the conversation.

Dr. Greenspan replied that regarding previous conversations, NCIPC was leaning toward leaving it as a grant program, but was also considering ways to allow the ICRCs to be more nimble (e.g., supplemental awards, cycles, other mechanisms, combination grant/cooperative agreement). She personally agreed that it is important to preserve some type of investigator-initiated grant, given that it does provide innovation. Though more of a technical CDC issue, she is also concerned with the amount of pressure they are getting from the Office of Budget and Management (OMB) regarding cooperative agreements and the possible need for OMB requirements for cooperative agreements. She would be reluctant to move this to a cooperative agreement if OMB is moving toward more requirements. That must be settled first before cooperative agreements can be considered for ICRCs.

Sunsetting ICRCs

Dr. Timmons agreed that keeping strong centers that have had long-term funding should be kept on line. However, she inquired as to whether ICRCs are required to supplement their infrastructure and funding for ongoing activities with other non-CDC funding sources. If so, would it be possible to taper funding over a number of years and use those funds to bring new centers on line? This would be a way to avoid the loss of productive centers and increase the geographic diversity and number of centers throughout the country.

Dr. Greenspan replied that NCIPC has thought about a mechanism for tapering funding, though they have not acted on this.

Dr. Allegrante endorsed the idea of a tapering mechanism. In addition to weaning the most productive centers where there is high quality work taking place, he wondered if funds could be set aside each cycle for only new competing centers under a separate parallel solicitation. He recognized that this might be complicated to do with tight resources; however, the BSC has repeatedly discussed the issue of the same groups being funded without new groups coming on line.

Dr. Greenspan indicated that NCIPC has tried to do this. One developmental center was funded for the current cycle. The eligibility criterion was that the applicant organization had to be a new center that had never successfully competed as an ICRC. Given declining funds, NCIPC could fund only one center and cannot afford that as a separate mechanism.

Dr. McClure added that if NCIPC funds a new ICRC, sunseting an older center will be necessary.

Dr. Houry clarified that they are not technically sunseting, but an existing center cannot continue to be funded if a developmental center is.

Dr. Greenspan indicated that this is what occurred in the current cycle. Funding a new developmental center meant that one of the full comprehensive centers could not be funded. Nevertheless, consideration must be given to other mechanisms for adding new talent.

Dr. Mickalide asked whether there is a possibility that a center that has been funded for a long time might be encouraged to collaborate with an institution on a project that has not been previously funded in order to seed that process for the next cycle.

Dr. Greenspan thought this was a good suggestion that NCIPC might be able to build into the next FOA.

Dr. McClure indicated that this is occurring already, so it should not be a problem. Some small seeding grants have gone through an existing ICRC to a non-funded institution to do the work.

Dr. Porucznik supported the idea of a planned sunseting so that successful long-term funded centers are encouraged to support their operations with other funding if possible. This is a means to give other places a chance and give them hope that there is a possibility of someday becoming a center. Currently, it feels as though it would be very difficult to “dethrone” a current center as a new center, even with criteria about geographic diversity or supporting young investigators. It is very difficult to compete with a successful, well-established machine.

Focused Topic Area versus Multiple Topic Areas

Dr. Mickalide asked whether every application is reviewed independent of all of the others, and whether NCIPC has a mechanism in place to ensure that all of its areas of interest are represented in all of the applications.

Dr. Greenspan replied that every application is reviewed independent of all of the others. The best way to ensure that NCIPC’s focus areas are addressed is through the FOA process. NCIPC has not been deliberate in terms of single focus centers in previous FOAs, which is why they are considering adding that to the next FOA. Peer reviewers evaluate applications in terms of what is stated in the FOA. Multi-focal centers may be in a better place to collaborate with health departments because they are working in multiple areas. A requirement of the FOA is that centers must reach out nationally, regionally, and locally to other health departments. A center with a single focus may be able to reach out to health departments on just one focus area. What is NCIPC’s responsibility in public health in terms of state health departments?

Dr. Porucznik pointed out that multi-focal centers are in a better position to train students as the next generation of injury researchers by offering a broader exposure to different methodologies and different topic areas, so they will be better prepared to address emerging challenges.

Dr. Allegrante thought that multi-focal centers might be able to achieve some synergies that single focus centers could not. There are also likely to be some common themes across various areas that could be pursued by multi-focal centers. He was inclined to say that they continue to support multi-focal centers.

Dr. Greenspan asked whether there is a place for single focus centers, or if NCIPC should concentrate on multi-focal centers.

Dr. Porucznik thought that for the scope and budget included in the last FOA for the developmental centers, it may be beneficial for developmental centers to have single or dual focus.

Geographic Diversity

Dr. Porucznik thinks geographic diversity is very important and is worth including a criterion for in FOAs. **Dr. Allegrante** agreed.

Dr. Mickalide stressed the importance of having an applicant pool of students who will form the next generation of leaders in injury and violence prevention and EMS. Oftentimes, students do not travel across the country to attend graduate schools. Having more opportunities on the West Coast will help to build a wider network of young professionals.

Dr. Houry agreed that NCIPC needs to support geographical distribution, but her concern is that there is a potential for problems. For example, what if there are 30 applications, only 6 centers can be funded, and all of the applications from the West Coast score in slots 20 through 30? Would BSC members support going down to that level for geographic diversity, or only when applications score somewhat close to the top? A decade ago, this was done by regions. Some of the regions were not very competitive, and some had funding issues and were on probation at various times.

Dr. Gorman-Smith agreed with Dr. Houry. It is one thing when scores are close and that decision can be made by going down one or two applications, but she would be really concerned if they pushed geographical representation over the quality of the applications. That is a difficult balance, but given the importance of these centers, NCIPC should not fund centers that are not likely to be successful.

Dr. Porucznik agreed and supported the idea of encouraging existing centers to partner with or potentially mentor a site that could become a new center. Perhaps there could be a stipulation that a site an existing center wishes to partner with or mentor must be in a different region or not in their same state. This is a way to “plant some seeds” in the middle of the Western part of the country by using existing resources to increase the quality of the applications.

Noting that she was still learning the process, **Dr. Houry** asked whether the BSC has a role in the discussion and providing NCIPC advice about geographic decisions.

Dr. Greenspan that in their role as secondary reviewers, the BSC could offer such advice. She put the members on notice that during the next secondary review of applications, NCIPC will be anticipating advice from the BSC.

Dr. Nation thought it might be helpful for the BSC and NCIPC to outline the guiding principles about the decision-making process. Quality appears to be the top guiding principle, but there are other principles that might also have an influence, all things being equal relative to quality, but are of less importance. He agrees with that assessment, but part of the discussion has regarded how to balance all of the other considerations in light of the central principle of funding the best and highest quality centers. It might be helpful to clearly articulate whether NCIPC has an order in mind about the characteristics, rank order, et cetera.

Dr. Greenspan thought this was a good suggestion and indicated that NCIPC could develop something for the BSC.

Dr. McClure agreed and thought this would be particularly helpful, given that otherwise it might appear that the funding decisions are somewhat ad hoc.

Developmental Centers

Dr. McClure said that funding only 1 or even 2 of 23 developmental center applications struck him as possibly being an ethical issue given the substantial effort required to apply.

Dr. Greenspan emphasized that the fact that there were 23 applicants points to the great need as well.

Dr. Houry stressed that ICRCs need to show impact. Developmental centers might be at a disadvantage for showing impact because they are focusing on building infrastructure. She requested input on whether there is another way to foster new ICRCs and label them differently.

Dr. Porucznik said she understood the conflict in terms of budget, but if NCIPC is not going to fund new centers or help build capacity, who is going to? If it is a priority to generate and support new talent, then some hard decisions will have to be made and there will have to be creative planning to ensure that there is a way to get more people into the field.

Dr. Houry asked whether she would suggest that along with geographical diversity, if an existing center scores 6 and a new center scores 7, priority should be given to the new center.

Dr. Porucznik thought this would be a great idea. She endorsed the idea of even having the developmental centers house a mentor center, or include a career development type of award stipulating the new investigators must have mentors to help them be successful.

Funding Cycles

Dr. Porucznik thought it would be reasonable in the next funding cycle to fund centers for three years to get them all on the same cycle.

Dr. Allegrante and others concurred.

Next Steps

Dr. Mickalide wondered whether CDC has assembled a compendium or report describing all of the successes of the ICRCs across the country over the last two decades that describes what has been learned, how the ICRCs have moved the field forward, et cetera.

Dr. Greenspan said she loves this idea and NCIPC has contemplated how to define the impact and successes of the ICRCs. Some additional funding has been provided to the ICRCs to document this. She invited additional input from the BSC about this effort.

Dr. McClure added that this is in the work plan and they will talk to the BSC further in the future about how to make it work best.

Dr. Greenspan concluded that it was nice to have confirmation about NCIPC's thoughts about moving forward. She expressed her appreciation for this conversation, which was very helpful for NCIPC. She invited any feedback in terms of whether this met the members' expectations regarding what a BSC should be doing, and other ways to engage in these discussions. She acknowledged that there have been frustrations on the part of the BSC and NCIPC in terms of how to best use the members' talents.

At the conclusion of this discussion, Drs. Fowler and Johnson rejoined the conference call. Dr. Fowler resumed her role as chair.

Updated: Pediatric Mild-Traumatic Brain Injury Guideline

Kelly Sarmiento

Designated Federal Official, BSC Pediatric Mild TBI Workgroup

Health Communication Specialist

National Center for Injury Prevention and Control

Centers for Disease Control and Prevention

Ms. Sarmiento reported that on October 16-17, 2014, the Pediatric Mild Traumatic Brain Injury Guideline Workgroup of the NCIPC BSC convened at the CDC Global Communication Center (GCC) on CDC's Roybal Campus for a two-day meeting. During this meeting, the workgroup discussed the findings from the scientific literature reviewed as part of this effort and began drafting the evidence tables and grading the quality of the evidence. In addition, they began drafting the systematic review that will help inform the clinical recommendations to be included in the guideline being developed. The workgroup is following an Institute of Medicine (IOM)-compliant clinical guideline development process.

The objective of the guideline is to improve diagnosis and management of mild traumatic brain injury (MTBI) among children and adolescents ages 18 and under through dissemination and implementation of the *Pediatric Mild TBI Guideline* in clinical practice. The dissemination goal is to increase knowledge and usage of the *Pediatric Mild TBI Guideline* among health care providers (HCPs) working in the acute and primary care settings. Once completed, the guideline will become part of the Heads Up Campaign. The strategies are to:

- ☐ Integrate the guideline into clinical systems and/or tools, such as electronic health records (EMRs)
- ☐ Engage medical organizations and workgroup members in promotion and dissemination
- ☐ Use a variety of distribution channels for reaching target audiences with key findings from the guideline to: 1) create and brand educational tools and messages using key findings from the guideline as part of CDC's Heads Up campaign; 2) leverage CDC and Heads Up

dissemination channels (website, social media platforms, et cetera); and 3) emphasize the use of mobile technology and digital resources (downloadable fact sheets, online trainings, et cetera)

- ☐ Appeal to HCPs' desire to be informed of the latest information that can help them do their jobs well
- ☐ Reach out to parents and other key stakeholders to help promote adherence to HCPs recommendations based on the guideline

Dissemination and implementation activities/tactics will commence with the publication of the guideline. A detailed plan will be developed to outline specific timing of each planned activity. Ms. Sarmiento invited BSC input on ways in which this effort can be enhanced to help reach HCP on a broad scale, and whether any activities, tools, or outreach opportunities were missing.

Discussion Points

Dr. Timmons expressed gratitude to the workgroup members because this has been a Herculean effort into which people put a significant number of hours of work, as well as Ms. Sarmiento and her team who have been extremely effective in shepherding this process. All of the efforts described represent fantastic ways to disseminate the guideline, but the ones that will be the most successful are the discharge instruction sheet and fact sheet. If the information and reference back to the full guideline can be placed into the hands of patients and families as they are leaving the hospital, that will take the information to the populace. The workgroup also plans to work closely with various medical societies to get them to endorse the guidelines through their guidelines processes, or at least disseminate them in order to distribute them to providers who deal with this problem.

Dr. Fowler inquired as to whether the discharge fact sheet would be downloadable from the NCIPC website.

Ms. Sarmiento indicated that they plan to create two versions, one that is a graphically designed PDF in English and Spanish that can be downloaded and printed and a text file version that can be uploaded into electronic discharge systems.

Dr. Timmons asked whether they have EHR companies working on an interface for this, or if it will be a Word file that will be disseminated to people to upload into their own EHR systems.

Ms. Sarmiento indicated that while having EHR companies work on an interface would be the ultimate goal, there are not current resources to develop a specific EHR interface. However, they hope to work with some of the experts who work with health systems that have their own systems set up and contact organizations such as Epic, Discharge 1-2-3 and other groups to offer these free resources. They have had success with this in the past. Usually, practitioners have to pay for content to upload discharge instructions into their systems. However, if NCIPC has something that has been developed by an expert workgroup, they are usually very excited to receive this type of information. Both strategies will be utilized. Two workgroup members have volunteered to work on the decision matrix component, which could help to inform an EHR in the future. However, that usually has a cost involved.

Dr. Fowler wondered whether before engaging in major dissemination efforts it might be worth conducting some selective outreach and collecting feedback from those with whom the guidelines are shared.

Ms. Sarmiento replied that there are two processes for that. One is a public comment period subsequent to the BSC's review. During that time, the team will be working with medical organizations that have been receiving updates throughout the process to review the guideline. Some formative testing of the information will be done as well. Some in-depth interviews have been conducted with the workgroup members to help inform the process. Working with the medical organizations and conducting outreach has been enlightening, and they will likely customize products moving forward.

Dr. Fowler asked whether they are working with any nursing organizations during the comment and dissemination periods.

Ms. Sarmiento replied that the workgroup includes nurses, physical therapists, EMS, and various physician specialties. They reached out to these same groups initially, who provided recommendations initially to get on the workgroup. These groups have been kept informed throughout the process, and will help NCIPC with implementation moving forward.

In addition to the technical issues occurring during this teleconference, **Dr. Fowler** recognized that some people had had limited time to review the guideline. With that in mind, she inquired as to how BSC members could provide additional comments.

Ms. Sarmiento confirmed that members could provide feedback to her, and stressed how helpful it would be to receive additional ideas to make the guideline the best it can be.

Dr. Greenspan indicated that those who did not have Ms. Sarmiento's email could email Tonia Lindley so that Drs. Greenspan and Cattledge could triage all of the questions.

Dr. Fowler officially thanked the Pediatric Mild Traumatic Brain Injury Guideline Workgroup for the stunning volume of work they completed in this effort.

Dr. Greenspan seconded that having seen their work internally and hearing from some of the workgroup members about the number of abstracts and papers they reviewed. The work they have done has been a Herculean effort.

Ms. Sarmiento said she would be happy to pass this on to the workgroup members.

Drs. Johnson and Testa requested assistance in helping several people change lines who were on the other teleconference number provided and did not hear this discussion due to technical difficulties.

Dr. Greenspan formally apologized for the technical difficulties.

Dr. Fowler briefed those who missed the discussion on what occurred and gave them the opportunity to vote.

Vote: Approval of Pediatric Mild-TBI Guideline Minutes and Update

Dr. Timmons moved to approve the Pediatric Mild-TBI Guideline minutes and update. **Dr. Allegrante** seconded the motion. The motion passed unanimously with no abstentions.

Updates: WISQARS Portfolio Workgroup

Sally Thigpen, MPA

Lead Evaluator, WISQARS Portfolio Review

Health Scientist: Division of Analysis, Research, and Practice Integration

National Center for Injury Prevention and Control

Centers for Disease Control and Prevention

Ms. Thigpen reminded everyone that during the last BSC meeting, she discussed some of the proposed methodology to propose the Web-based Injury Statistics Query and Reporting System™ (WISQARS™) portfolio review. At that time, the BSC members provided a number of great suggestions that were incorporated into the methods. The overall goal of the review is to obtain actionable recommendations to guide NCIPC in planning and allocating resources for WISQARS.

Although data collection has been completed, there were not a lot of findings to share at this point. Some data are still being analyzed. The findings will be added to the evaluation report, which has been partially drafted and is being completed by the evaluation contractor. Four major methods of data collection were utilized, including stakeholder interviews, a Google content analysis, an environmental scan, and a literature review. Ms. Thigpen shared some preliminary results from each of these methods.

Forty-three stakeholder interviews were conducted to fill gaps in the understanding of users' data needs, accessibility of the system, and how data are being used. Interviews included diverse internal and external end user groups, including individuals from communication and policy, federally funded research centers, academia, state health departments and non-governmental organizations. Based on preliminary findings, interviewees provided several suggestions on topics such as including interactive features in data displays, expanding statistical capabilities, and better access to state and regional data. About half of the internal and external stakeholders participated in some form of WISQARS training or online tutorial. Ms. Thigpen noted that they were limited to nine external stakeholder interviews. Fortunately, they were able to interview some NCIPC BSC members whom she thanked for their time and sharing their insights. They were able to count those interviews as internal, which was beneficial.

The idea for a Google content analysis stemmed from the early interviews. To get a more organic gauge of how end-users are tapping into WISQARS™ data, a content analysis of the first 100 pages that appeared on a keyword search "WISQARS" was conducted. All sites with a cdc.gov web address were excluded. Approximately 200 web addresses were reviewed to locate 100 sites that were not related to CDC. Each of the 100 pages was reviewed by three evaluators and data were entered onto an Excel spreadsheet and stratified into broad categories. Preliminary findings show that 41% of sites were sponsored by non-governmental organizations (NGOs). The Fatal Injury Data Module was the most commonly cited. The coding structure used was assessing content by topic area, which was found to be difficult because 44% of the sites presented an overview of injury prevention or WISQARS data without

mentioning a specific injury topic. Therefore, some adjustments had to be made to the coding structure. Suicide (n=25) and firearms (n=23) were the topics most frequently addressed.

An environmental scan of internal and external web-based data query systems (WBDQS) is currently being conducted. The primary goal is to identify, inventory, and categorize relevant WBDQS and then document the technical and other features of the query interface. While all of the data have been entered, the analysis is still being done.

A peer-reviewed literature review was conducted to identify information regarding the use and usability of web-based data query systems. There was very little, although that is not surprising. Based on specific search terms, 48 articles were reviewed and summarized. Of the 48 articles reviewed, 32 articles had information directly relevant to the specific objectives of the literature review. Pertinent information from the 32 articles was entered into an Excel spreadsheet under the relevant topic. Based on preliminary findings, recommendations for WBDQS are to include a wide range of relevant data sets, and offer the capacity to view geographic data; offer multiple avenues to initiate queries (different variables); and provide customizable reports.

A grey literature review was conducted of informally published written material (such as white papers, dissertations, and policy reports) that cited WISQARS™ as a significant data source. The New York Academy of Medicine (NYAM) Grey Literature database was searched, using several combinations of search terms. Nine unique citations were identified. Based on preliminary findings, the nine reports focused on injuries that were intentional (3), unintentional (1) or both (5). Seven reports concerned firearm-related injuries, one addressed hospital stays related to violence, and the final report examined intimate partner violence fatalities.

Regarding next steps, an environmental scan will be completed and data analyzed and integrated into the report. The draft will be reviewed by the NCIPC core team, workgroup, and the Associate Director for Science (ADS). The draft report will be presented to the Expert Panel in March 2015 for recommendations. The final report and recommendations based on the Expert Panel Portfolio Review will be presented to the BSC during the next meeting.

Discussion Points

Dr. Fowler commended Ms. Thigpen and the team. It was clear to the BSC members who were asked to provide input into the design early in the discussion that those suggestions were incorporated into the design, for which she expressed the BSC's gratitude.

Ms. Thigpen thanked the BSC members for their guidance, which was very helpful.

On behalf of the BSC, **Dr. Fowler** said that she would like to offer enormous thanks to Dr. Annest for his extraordinary vision for and leadership of WISQARS™. He has given the field an enormous gift with this vision.

Dr. Mickalide noted that during the APHA meeting, he received no fewer than four standing ovations in different sessions when his retirement was announced. He has been a wonderful partner and mentor to many people across the country.

Dr. Greenspan indicated that they would let Dr. Annest know on behalf of the BSC, and she echoed that he has been an enormous mentor within CDC and has really moved the field forward in surveillance. This will be a major loss for NCIPC. DARPI is working on a seminar

that will reflect on Dr. Annest's work and to officially thank him. The BSC's "thank you" can be worked in there as well.

Dr. Cattledge asked whether through Drs. Fowler and Mickalide, the BSC would like to craft an official letter. This can be put on an official BSC memo with signatures.

Dr. Fowler thanked Dr. Cattledge and indicated that the BSC would very much like to do this.

Vote: Approval to Formally Commend Dr. Annest

Dr. Mickalide moved to approve the BSC's desire to formally commend Dr. Lee Annest for 34 years of service, vision, and impact on the field and wish him the best in all his endeavors. **Dr. Allegrante** seconded the motion. The motion passed unanimously with no abstentions.

Public Comment Period

No public comments were provided during this meeting.

Closing Comments / Adjourn

Carolyn J. Cumpsty Fowler, PhD, MPH
Assistant Professor
Johns Hopkins University School of Nursing
Bloomberg School of Public Health
Member and Chair, NCIPC Board of Scientific Counselors

Given the significant number of technical difficulties during this teleconference, **Dr. Fowler** requested that in the future, NCIPC dedicate a staff member to serve as the official contact and to monitor email to enable BSC members to make contact during the call.

Dr. Cattledge indicated that the next in-person BSC meeting will be July 16-17, 2014. **Dr. Greenspan** noted that the secondary review will be conducted during one day of that meeting. She expressed gratitude to the members retiring from the BSC for whom this teleconference was their last official meeting for their hard work and wisdom. She thanked Dr. Fowler not only for her participation, but also her leadership. She also thanked Drs. Borkowski, Gorman-Smith, Nation, and O'Connor for their academic work in this area and their contributions to the BSC.

Dr. Fowler thanked everyone for a great morning of discussion, interest, and participation. She reminded all BSC members to email Tonia Lindley at ncipcbosc@cdc.gov stating for the record that they were on the call. She welcomed Dr. Houry, expressed delight that she is at the helm, and wished her the best. Dr. Fowler thanked the BSC federal liaisons, CDC staff for their participation and meeting coordination and support, and the Writer/Editor from Cambridge Communications, Training, and Assessments (CCTA) for her support services. With no announcements, further business, or questions/comments posed, Dr. Fowler wished everyone a great holiday season and officially adjourned the sixteenth meeting of the BSC at 12:00 pm.

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the December 9, 2014 NCIPC BSC meeting are accurate and complete:

April 7. 2-15
Date

Carolyn J. Cumpsty Fowler, PhD, MPH
Chair, NCIPC BSC

Attachment A: Meeting Attendance

BSC Members

John P. Allegrante, PhD

Deputy Provost
Teachers College
Columbia University

John G. Borkowski, MD

Professor
Department of Psychology
University of Notre Dame

Carolyn J. Cumpsty Fowler, PhD, MPH

Assistant Professor
Johns Hopkins University School of Medicine
Bloomberg School of Public Health

Deborah Gorman-Smith, PhD

Chicago Center of Youth Violence
Chaplin Hill at University of Chicago

Sherry Lynne Hamby, PhD

Department of Psychology, Sewanee
The University of the South

Robert L. Johnson, MD

Dean
University of Medicine and Dentistry
New Jersey Medical School

Angela D. Mickalide, PhD, MCHES

Executive Director
Emergency Medical Services for Children's National Resource Center
Children's National Medical Center

Maury Nation, PhD

Associate Professor
Department of Human and Organizational Development
Vanderbilt University

Robert O'Connor, MD

Professor and Chair
Department of Emergency Medicine
University of Virginia

Christina A. Porucznik, PhD, MSPH

Assistant Professor
Department of Family and Preventive Medicine
University of Utah

Maria Testa, PhD

Senior Research Scientist
Research Institute on Addictions
University of Buffalo

Shelly D. Timmons, MD, PhD, FACS

Director of Neurotrauma
Department of Neurosurgery
Geisinger Medical Center

Federal Liaisons**Dawn Castillo, MPH**

Director
Division of Safety Research
National Institute for Occupational Safety and Health

Elizabeth A. Edgerton, MD, MPH

Branch Chief
EMSC and Injury Prevention
Maternal and Child Health Bureau
Health Resources and Services Administration

Lyndon Joseph, PhD

Health Scientist Administrator
Division of Geriatrics and Clinical Gerontology
National Institute on Aging

Iris R. Mabry-Hernandez, MD, MPH

Medical Officer, Senior Advisory for Obesity Initiatives
Center for Primary Care, Prevention, and Clinical Partnerships
Agency for Healthcare Research and Quality

Jane L. Pearson, PhD

Associate Director for Preventive Interventions
Division of Services and Intervention Research
National Institute of Mental Health

CDC Staff and Others**Gwendolyn Cattledge, PhD, MSEH**

Deputy Associate Director for Science, NCIPC

Erin Connelly, MPA

Director, Office of Communications, NCIPC

Arlene Greenspan, DrPH, MS, MPH

Senior Scientist, Motor Vehicle Injury Prevention Team

Heidi Holt

Public Health Advisor, DARPI

Debra Houry, MD, MPH

Director, NCIPC

Tonia Lindley

Committee Management Specialist, NCIPC BSC

Rod McClure, MBBS, PhD, FAFPHM, FAICD

Director, DARPI

Karin Mack, PhD

Science Officer, DARPI

Sara Patterson, MA

Director, Office of Policy and Partnership, NCIPC

Amy Peeples, MPA

Acting Deputy Director, NCIPC

Kelly Sarmiento, MPH

Designated Federal Official, BSC Pediatric Mild TBI Workgroup
Health Communication Specialist, NCIPC

Thomas R. Simon, PhD

Behavioral Scientist, DVP

Jane Suen, DrPH, MS

Health Scientist, NCIPC

Sally Thigpen, MPA

Lead Evaluator: WISQARS Portfolio Review
Health Scientist, DARPI

Stephanie Wallace

Senior Scientist / Technical Writer, CCTA

Attachment B: Acronyms Used in this Document

Acronym	Expansion
ACIPC	Advisory Committee for Injury Prevention and Control
ADS	Associate Director for Science
BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
COI	Conflict of Interest
DARPI	Division of Analysis, Research, and Practice Integration
DVP	Division of Violence Prevention
EMR	Electronic Health Records
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
FACA	Federal Advisory Committee Act
FEVS	Federal Employee Viewpoint Survey
FOA	Funding Opportunity Announcement
HCP	Health Care Providers
HRSA	Health Resources and Services Administration
ICRC	Injury Control Research Center
IOM	Institute of Medicine
IPV	Intimate Partner Violence
MASO	Management Analysis and Services Office
MCHB	Maternal and Child Health Bureau of the Health
MTBI	Mild Traumatic Brain Injury
MV PICCS	Motor Vehicle Prioritizing Interventions and Cost Calculator for States
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCIPC	National Center for Injury Prevention and Control
NGO	Non-Governmental Organization
NYAM	New York Academy of Medicine
OMB	Office of Budget and Management
PRC	Prevention Research Center
SAVIR	Society for Advancement of Violence and Injury Research
SME	Subject Matter Experts
SV	Sexual Violence
WBDQS	Web-Based Data Query Systems
WISQARS™	Web-based Injury Statistics Query and Reporting System™